

# The Boston Medical and Surgical Journal

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### Original Articles.

#### MODERN ART AND MASS PSYCHO-THERAPY.

BY SMITH ELY JELLIFFE, M.D., PH.D., NEW YORK.

POWER and self-expression are synonymous terms. Both, moreover, are merely word symbols for that force, or energy, which lies at the source of our nature and informs every part of it, or seeking to do so, wages an intolerant strife against any portion which thwarts this fundamental urge or fails in contributory response. Its inherent tendency is to ally all the capacities of one's being and open all the avenues toward completeness of expression. It seeks in the same imperious way to overcome external objects in turning them to its account.

The term imperious implies not the tyranny of ruthlessness but suggests rather the rightful possession of this all-embracing *imperium* which claims all nature for its territory of activity and molds and conforms all objects to its service. For its service rightfully considered, though often grievously distorted in subjective and objective hindrances to expression and always incomplete, is nevertheless inherently a constructive and a creative one.

The phrase "creative in art" has been so bandied about that like many of our most sig-

nificant word symbolisms the dynamic reality which lies behind it escapes our thought and appreciation. What, then, is the creative? Deep down in the individual human life and far back in racial history, as far as even imagination can guide us, we discover at work this inherent dynamic necessity to create, to impart life that it may continue progressively, immortally. It is only in the higher refinements of the intellectual life that we distinctively recognize this impulse and bring it to definition. Long before that, however, individual and race alike are emotionally aware of its overwhelming power. It sweeps us on far beyond the confines of mere physical procreation, important and intense enough in itself, but requiring for its fullest meaning and purpose the manifold desexualized forms of the action of the creative impulse, those which man has discovered and developed and those which yet lie before him.

The creative need and with it the power idea inseparably bound with art, whether in its broader or more limited technical sense, is historically lodged in the etymology of the words employed to designate art in various languages. Sidney Colvin writes in the *Encyclopedia Britannica*: "The Latin *ars*, according to the prevailing opinion of philol-

ogists, proceeds from the root AR, of which the primitive signification was to put to or to fit things together. . . . The Greek *τίκτειν* . . . is by its root related both to *τάκτων* and *τίκτων*, and thus contains the allied ideas of making and begetting. The *proprium* of art in the logic of the Stoics, 'to create and beget,' was strictly in accordance with this etymology. The Teutonic *Kunst* is formed from *können*, and *können* is developed from a primitive *Ich kann*. In *kann* philology is inclined to recognize a preterite form of a lost verb, of which we find the traces in *Kin-d*, a child; and the form *Ich kann* thus meaning originally 'I begot,' contains the germ of the two several developments, —*können*, 'to be master,' 'to be able,' and *kennen*, 'to know.' We thus see that the chief Indo-European languages have with one consent extended name for the most elementary exercise of a constructive or productive power, till that name has covered the whole range of the skilled and deliberate operations of sentient beings."

Man's creative impulse has not found his materials always ready at hand nor his means of manipulation. If his ego-consciousness has oftentimes looked backward with a self-gratulatory "*Homo sapiens*," nevertheless his history has been one long practical illustration of *Homo faber*.<sup>2</sup> Man the craftsman, the smith who must not only mold all to his one great purpose but must even fashion his own tools for the work, inventing them, fitting them into shape, altering and refashioning them with enlarging experience and the need in expansion for more adequate forms of expression, this is the being with whom we have to do, who, when all is said and done, commands our serious attention and sympathetic approval. We need not count on his failures, his inadequacies. We are on the lookout for his successes as so much accomplished in the broadening of opportunities for expression and thus attaining by degrees an ever fuller immortality. The failures reveal the limitations still existent and the hindrances within or without and are therefore guides pointing to a wiser and more effectual choice and use of means.

It is to a certain degree the incompleteness of result in individual striving, together with inability to reach the highest and fullest expression which leads to the diversity of

methods of self-expression and individual differences of comprehension of these methods.

The field of modern art furnishes us with striking illustration of these various principles and facts. Here, if anywhere, the demand for more diversified expression has made itself felt. Here also *Homo faber* has had to construct his tools and adapt them to newly felt needs and by so doing has freed certain repressions which had long been holding the sense of power under restraint and against which it necessarily chafed. We might, therefore, almost call modern art a form of practical psychotherapy. In fact, we need not hesitate to do so, from the point of view which regards disease as the want of perfect adjustment to environment and inadequate control of that environment, and, therefore, limitation of creative power. By just so many tentacles, as it were, by which the modern artist touches that environment and reaches it with a new power to put it into an extended variety of expression, by so many means does he touch among other issues some of the repressed factors of psychical life in others, which, too, seek outlet and which are sometimes left behind in the process of sublimation to become active sources of mental distress and disarrangement or of perverted exercise.

This does not mean that the art of today reaches only a lower degree of attainment. Nevertheless it cannot be disputed that it is rich in expression of many impulses and tendencies, undeveloped and infantile forms of the great initial creative impulse, which find in this art a symbolic expression formerly denied them so openly and freely. Modern art is a product, and a factor no less in its establishment, of a condition of society toward which humanity has striven under its bonds. This state of things allows a greater latitude for individual expression and conduces to larger individual conception. It tolerates a symbolic admission and pictured representation of the "polymorphous tendencies" of human desire which find expression at varying levels of psychical development and culture and gives safe outlet for artist and spectator alike. Time was when any deviation from the accepted modes of outlet and departure from the thickly conventionalized covering which hid vital dynamic meanings met with very real persecution, religious ex-

communication or at least complete social ostracism. Now, at the worst, there is only a supercilious ignorance and lack of understanding on the part of those who still remain safely and adequately entrenched in convention. Otherwise culture provides a freer atmosphere for creative expression permitting various types to work out fittingly their own salvation and offer to others the same outlets which the latter are less able to put into expression for themselves.

A simple illustration may serve as a concrete example of the freedom which the modern artistic conception has brought out of the formal conventionalities which for a vast number harfully repressed too much. The illustration may seem grotesque to some, as bizarre as, superficially, much of this art itself seems. Remember, however, that we are dealing with undeniable facts in human life, facts which a sober analysis of a psychical maladjustment and consequent ineffectualness brought to light. Walter Pach has recently exhibited a little picture named "The Snow." It is a marvel in the depth of conception displayed in its dramatic employment of color and of the representation of the three dimensions enhanced by the rhythmic use of the line, as Willard Huntington Wright<sup>8</sup> has expressed some of the chief features of the modern methods. No snow is visible to the superficial observer, but to one who has learned to follow psychical life beneath the surface there is striking imagery and analysis of what may lie within snow for the sense of power and its expression in the artist's result. The artist's free interpretation sets itself in marked contrast over against the rigidly limited expression allowed by her conventional world to a patient who had made a quite different use of the same mental factors. Her life had been wasted in a futile attempt to deny through long accepted terms the elemental impulses which were striving behind the pure white religious exterior which was trying to congeal these elements in a sublimation which had become empty for this individual, would not "work." Her struggle had been a long and most painful and incapacitating one against the idea of moral impurity mostly of a pronouncedly sexual nature. It was originally it may be said, entirely of a sexual nature, as analysis plainly showed, but while the sexual

character of it persisted painfully into consciousness it had also been pushed over upon all sorts of moral sinfulness and the theological idea of uncleanness in all respects before God. This was all, be it understood, in the patient's phantasy and the sexuality was largely of an infantile phantasy character. This in turn extended itself to a compulsive need for striving after eternal physical purity as well. So there had resulted in the patient's daily life a most elaborate and oppressive prayer ceremonial, the burden of which was the prayer for cleansing, and with it a constant handwashing which in turn had extended itself to elaborate ceremonial observances in regard to cleanliness of all parts of the body, particularly the genitals, at the time of prayer or other religious exercise.<sup>4</sup> "Wash me and I shall be whiter than snow" was literally the burden of her ineffectual cry against the impulses to power she could not understand and control. It took a long course of psychical analysis and revaluation, reeducation, to melt away the cold convention and reveal to her the rightful reality of the depth of warm vital color beneath, manifest in the impulses against which she battled, and to unite these struggling elements of power in contact with reality which created useful sublimated products instead of freezing over their vitality through a meaningless unproductive exterior. In this instance the artist's conception possesses a more truly pragmatic value than the psalmist's chaste prayer.

This gives us a glimpse of the service of much of this modern art in discovering and utilizing such multifarious and, we might say, unexpected ways of discharge. They are ways of the artist's own creation, for the creative impulse finds no small part of its satisfaction in the necessary invention and fashioning of its own tools. Therefore, the artists have developed form and color in response to the increasing need in the manner of sublimation which discovers itself in the new conceptions and evolution of these as much as in the use to which they are put.

A study of unconscious symbolism adds a further value to their employment of these elements even to the extravagance in which, for example, certain of their colors predominate and appear again and again. The power with which one is able satisfactorily to lay hold of nature for himself and for those to whom his art is a permanent message lies apparently for

some in the undeveloped infantile phantasy form which deals with food and fecal birth phantasies. Such an artist's efforts, perhaps, are not far from the infantile and primitive level, which maintains a certain influence still upon all adult life, but which is particularly prominent in neurotic immature individuals. Here, then, is opportunity for power satisfaction on this level in the liberal use of brown, in the still-life studies pertaining to kitchen and dining table, the contemplative studies of chocolate grinders with the chocolate "spilt all over it," according to a comment overheard in passing. The food symbolization, associated as it is in the pictures with symbols suggestive of reproduction, paints with lavish hand a universal complex which bears much more than a nutritive meaning in its self-expression of one of the earlier forms of power seeking.

Another complex expresses itself and so discharges its desire in the purple that surrounds particularly the human figure. The force of this symbolism, too, is discovered where we find the need and the attempt for expression in so marked a degree, in the unconscious life which is revealed through the neurotic symptom, the dream and the day phantasy. As the purple plays there about the death phantasy in various aspects, self-destruction or self-immolation and thus a height of ecstasy through death, or the unconscious wish of removal by death of a rival, so in the phantasy to which the artist gives expression there is probably a subtle gratification of his instinct to power which would thus symbolically experience the death ecstasy, or the triumph through death over a rival, or the subjugation of the loved one, in that close unison between death and erotic love which a study of the unconscious has revealed. The revelation of the sense of power that comes to one on even a superficial examination of Wilson's "Neo and Angel," where the virile strength and determination depicted in the faces of the bull-fighters is accentuated by the skillful introduction of a deep rich blue into their garments confirms also the psychoanalytically discovered association of blue with a strong desire for mastery. The psychology of colors as revealed in work with the unconscious is yet too much in its infancy to allow more than a few suggestive hints of the value which the newly developed use of color through the work of the modern school has in these manifold reachings

after expression. Their use of color and their interpretation of it must bring us into a deeper understanding of its unconscious meaning and therefore expressive capacity. The symbolic use of color is as old as the first repression of actual meaning into the unconscious and its escape externally only through symbolic forms. This freer use of color as art has developed it provides more extensive outlets for the ancient repressions.

There is complexity of desire and a breaking from restraint in the use of forms in manifold multiplicity with the free employment of the line, which the artist breaks and shifts to follow freely the meaning conveyed. This also is full of the significance of active desire. It is to them, in impressive form, motion, which is the symbol for the inexpressible something within which demands all this endeavor. Lanier's clear vibrant lines have sung it in poetry:

"I will fly in the greatness of God as the marsh-hen flies  
In the freedom that fills all the space 'twixt the  
marsh and the skies;  
By so many roots as the marsh-grass sends in the sod  
I will heartily lay me ahold on the greatness of God."

There is no limit to the desire that moves with such a beating of wings nor is there any limit to the multitude of roots through which this mastering contact with reality must take place. This desire has worked through all mysticism, all poetry, through the setting up and bringing down of governments, through all the progress and invention of practical life. But the special diversity of manifestation which is here under discussion has been able to throw out many fibres and rootlets which have otherwise been stifled and cut off from healthful activity. Instead it now presses itself into reality through these and finds them likewise living channels toward certain varying degrees of immortality and therefore adequate for expression.

We cannot all attain to an adequate discharge of our sense of individual power in the same way nor find the same forms of expression satisfying. The impulse to power and the need to express it and impress it upon our own contribution to immortality is the same, while the means differ widely. In view, therefore, of our common need as well as of the existence in all of us of unsuspected factors in our psychical life which we share with all, it behooves us to recognize the service which this field of art renders to ourselves and to others in the path of

sublimation. It may suffice for harmless discharge of otherwise repressed and therefore disturbing partial impulses. Again it may be the very level of sublimation that gathers one's forces into effective unified production, or it may point the way to higher and still more adequate direction of the instinct to creative power.

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- <sup>3</sup> Wright: Introduction to The Forum Exhibition of Modern American Painters, 1916.
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## SHALL WE NEVER LEARN?

BY D. M. LEWIS, M.D., NEW HAVEN, CONN.

NOT only because so-called Spanish influenza is epidemic in isolated areas of this country, but because of the daily board of health publicity given on the prevention of its epidemicity in such communities and its irrationality, more than remonstrance may be in order. It may be in order to take stock as a preliminary as to terminology. The late spring and summer saw influenza epidemic in England, statements to the effect that there was a frequency in France and Germany, later that it had been epidemic in Spain and spread to Italy. At the same time it was in the interior mountain regions of Peru, so universal as to close down mining and smelting works. In Italy it was recognized not as influenza, failing the respiratory signs. In England there was a following "new" encephalitis. Nowhere has it been recognized as due to the influenza bacillus, but generally termed influenza or gripe from the two predominant characteristics, speed of spread, and pneumonic complications. Because of these two characteristics communities give out the usual antiquated publicity: avoid exposure by not going where there is illness (to warn the public it is stated that cases must be reported and rooms at least placarded), avoid public places and gatherings, avoid coughing or sneezing individuals, secure proper ventilation and observe usual rules of hygiene. Proper care of the spread becomes dependent, then, on the proper care of the one ill, and any spread depends on the usual abortive cases not ill in bed. These are the stock rules for all epidemic diseases, and from time immemorial, as is history, have never stopped any disease. Recurrently, Nature strives by her experiments (not crude as some sanitarians state), to demonstrate how

she works. Recurrently with each epidemic the same time-worn stand is taken, although more intelligent study may be given the cases, while the laboratory is stimulated to the study of an antitoxin and preventive inoculation. What may we learn in nature's field if we go hunting. Embodied in a former paper,<sup>1</sup> the result of immediately previous, interim, and the immediately following period of the last influenza or gripe epidemic, I showed that, whether due to the influenza bacillus, a streptococcus, as was evident, or a pneumococcus as conceivable, the important demonstrable facts were that as the greatest public health problem of the day it had numerous primary infections leading to fatalities, and that it stirred up previously latent infections, causing fatalities, and, as well, stirred up late frequency of such infections. The primary infections were respiratory, gastro-intestinal and central nervous system; it stirred up preëminently tuberculosis, measles, diphtheria, scarlet fever, meningitis and poliomyelitis. The method of combat was start with the case and by examination of all previous immediate contacts find the carrier. Go further by assuming responsibility; teach the educated public what head colds mean, and to disinfect them; go among the uneducated, the school children and the institutional, and by nurses seeking head colds, isolate and cure specific unusual head colds, watching the ordinary one that it should not later become specifically contaminated. I have shown the number of such unusual germ-laden noses that may be found by simple inspection; that by culture we find them either the streptococcal grippal or in combination with diphtheria, the pneumococcus, the meningococcus, or the three other kinds of streptococci found epidemiologically to lead to measles, scarlet fever or poliomyelitis. Having found them merely by inspection, having isolated them and cured them by the constant use of old fashioned—well founded on clinical experience—nasal antiseptics, there have been two facts demonstrable: control of by absence of secondary and return cases and the continued consequent diminution of cases and deaths from each and all the other respiratory diseases, in terms of previous similar epidemics and in terms of other neighboring cities having the same condition.

Incredulity and complacency, foster parents of opposition, were shown by the Board of

Health Commissioners of this city in latter 1916, when I requested that grippe be made a reportable disease; that because from September, 1915, to September, 1916, I had isolated 21 nasal carriers of diphtheria, 8 of scarlet fever, and 28 of streptococcal gripes, the latter predominant problem called for an added force of nurses to do this work. Both were refused. Appeal the following month to the physicians through the monthly bulletin to report cases that contact carriers might be found also, brought no attention. Impersonally, the attitude was because the sponsor was "walking alone." At basis, then, an epidemiologist alone of any in any community of this country, working in the field rather than as others working on cases or suspects, finds definite conditions which, with the partial treatment available from inadequate assistance and time, can show definite results. As impersonal, have there been any, and what corroborative findings, of others working on cases only?

Literature has been full of such confirmatory material, isolated in places and amount; disjointed and lacking basic foundation. Among them is the face mask to control cross infection; the demonstration of nasal sinusitis,<sup>2, 3, 4</sup> of cases with the inference that such, as chronic may be the starters of epidemics; the confirmation that the streptococcus throughout the army camps of 1918 and not the pneumococcus was the death-dealing or complicating factor; that carriers of such were made in clean wards by attendants; that a certain per cent. of carriers showed signs of inflammation; that during an epidemic of pneumonia there were cases of scarlet fever in such smaller proportion as to lead one to ask why if milk streptococci caused the frequency of pneumonia there were not more cases of scarlet fever; that after an attack of measles the one ill within a month developed another kind of measles; that a scarlet rash was frequent in grippe as shown by the absence of scarlet fever during or at the expiration of the attack; that epidemiologically there is a connection between influenza epidemics of the winter, following cerebrospinal meningitis and yet later poliomyelitis.<sup>5</sup>

If now we fit all these observations of the epidemiologists who find such from consideration of cases only, with the previous observations made by me from finding what was the cause of producing each case as everywhere is done with typhoid, as we have done with diph-

theria, scarlet fever, and less with the other respiratory diseases, I can see no lack of confirmation of why complications of cases arise and why there is not an orderly sequence. The essential confirmation of the carrier has not been reached for two reasons: first, the theory that spread of disease radiates from the one ill holds the center of the stage, or if the carrier among the contacts is also considered, it is from the standpoint of what cultures show not what the nasopharynx shows. Field work has shown the fallacy.

Because, then, other equally observant epidemiologists could find, and would, the same basic point if they would so examine all contacts of the one ill, or all individuals if there were no cases; because a respiratory disease is epidemic and non-controlling preventive measures are advocated; preëminently because of the sequence of what diseases follow respiratory grippe, I submit that it is in order for boards of health to assume the responsibility not only of investigating the unusual head colds found among contacts of cases and of the populace at large, irrespective of cases (the pharyngeal involvement alone is at the time of lesser importance—why, I have previously shown) but compel by isolation and constant nasal inhalation of a rational antiseptic, the cure of that contagious material which makes cases faster than cases can make cases and carriers faster than cases can make carriers. (Confirmation of nasal treatment was offered possibly as a coincidence by one army camp, the only one using it and the only one having not only less following frequency of the epidemic disease, but of other diseases following. This was dichloramine-eucalyptol, analogous to, though from my experience of no greater value than, camphor-eucalyptol.) The chronic recurring carrier will be found to be more generally the one who has previously had the disease, has a chronic sinus and nasal deformity, presents more than the innocuous watery head cold, but transmits to such latter the organism and not infrequently more than one variety. That cases follow not the original carrier but consequent on the fresh carriers, who apparently, from the duration and the course of the nasal inflammation do not have necessarily sinus involvement, is as apparent in streptococcal, as is known in diphtheritic carriers. The simplicity of control measures are those formerly assured under sanitary premises; the passing

by of normal naso-pharynges, the further observation of ordinary head colds only when chronic demonstrated carriers are simultaneously or later found in the neighborhood or known friends of such individuals. Not the masking of attendants and carriers carried to the outside world demonstrable carriers, not the treatment of known cases by an isolation hospital, is the cure of any respiratory disease frequency. It lies in the fear of, the demonstration of, and the cure of specifically laden nasal discharges primarily, the control of which fundamentally lies in the board of health; not in educational propaganda, but by direct action among that part of the populace where incidence of any and all diseases always exist for reason of carelessness and inattention, not always coincident, and poverty likewise not always coincident with the former two. The lesser populace and the physicians should represent the class to be reached by education—yet the theory there does not always work out.

Because then of a personal knowledge of how to control respiratory frequency gained from applying procedures during and after an epidemic of grippe or influenza so called, in terms of similar rational procedures gained previously from other respiratory diseases, and all such observations have been confirmed in disjointed parts though it be (because of consideration of cases only), I would make an appeal for result-gaining methods as against the same ineffectual publicity-case controlling methods as have never controlled not only the dominant disease but any consequent following disease as well. The fact that this community does not know from the comparative number of cases contrasted with the coincident high frequency of our neighboring cities whether they have the disease, is exactly measured by the large numbers of respiratory carriers, mainly streptococcal, who have been found and cured during the past two and one-half years during and following the last epidemic. For that reason we can predict not only less frequency of the disease and deaths but similarly a less frequency of later following diseases,—measles, diphtheria and encephalomyelitis,—than our neighboring cities. We all have the same state law, put out by each board of health; each has the same newspaper publicity, laying the responsibility for spread on the public or on physicians for not reporting cases. It is stated to be standard. Standards are more slowly changed

among the medical profession than even the law. Is there not sufficient evidence at a time that even minor illnesses mean retardation of work at the least, let alone fatalities, to break away from standardization by trying out accumulated evidence?

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## NEUROSES AMONG RETURNED SOLDIERS. TYPES AND INDICATIONS.\*

BY CAPTAIN CLARENCE B. FARRAR, C.A.M.C., OTTAWA.

*Psychiatrist to the Military Hospitals Commission of Canada.*

(Concluded from page 589.)

CASE 6.—*Trench Spine*.—This soldier, formerly a collier, enlisted in August, 1914, aged 34. He reached France with the first Canadian contingent in February, 1915, and saw practically continuous service until his casualty in August, 1916. He was in the trenches at Ypres and buried during bombardment, a timber falling across his back. From that time he complained of severe pain in the lumbar region and has been unable to stand erect. A medical board held September 22, 1916, noted: "He still has pain in the lumbar region, part of which may be functional." For two weeks following the casualty patient was unable to walk.

Returned to Canada February 11, 1917. Patient stands in a stooping posture with torso tilted to an angle of about 60 degrees from perpendicular. Walks with a cane. When sitting he bends over in the same way, inclining his body to right. He states that it is quite impossible for him to assume the erect attitude. When directed to lie on his back he raises his shoulders from the bed by supporting himself on his elbows; and when this support is removed and his shoulders are forced down, the thighs are at once flexed in compensation. He can be brought gradually to a posture approximating complete extension. This manipulation is accompanied by some tremulousness and complaint of pain in the back. There is hyperten-

\* Paper read at the Symposium on Psychiatry and War held by the New York Psychiatric Society, Dec. 5, 1917.

us of the back muscles which increases on passive movement.

Invalid makes no other complaints and physical examination shows no cause for disability. There has been no injury to the vertebrae or cord and no present evidence of contusion or other lesion of the soft parts. This is the functional nervous disability which the French call camptoecormie, and which is the legitimate descendent of "railway spine."

**CASE 7.—Hysterical Anaesthesia.**—This case of "shell shock" never escaped from camp on this side of the water. He enlisted about May 10, 1916, giving his age as 44 (believed to be 55), occupation—butcher. In June, following some exposure to dampness he began complaining of pain in the back and was treated at first for lumbago. Soon after he was complaining of loss of sensation in the legs and the anaesthesia promptly became general. A moderate degree of arteriosclerosis, with blood pressure of 175, was practically the only somatic finding. After two months in the army, patient was discharged as medically unfit.

His case unfortunately attracted some attention medically, and he has suffered from a multiplicity of diagnostic suggestions, including locomotor ataxia, arteriosclerosis of the nervous system, ascending paralysis, syringomyelia and hysteria. Ascending paralysis appears to be the diagnosis which the patient recalls with the most satisfaction.

In this case a source of grievance existed from the beginning. The patient maintains that he should have received special pay as a meat cutter but received only the ordinary pay of the private. The complaints which he promptly made on this account were without result.

His discharge he looked upon as very unjust, and symptoms of disability increased. He repeatedly requested to be re-boarded. He was finally admitted to hospital and a medical board, November 27, 1916, reported: "After prolonged observation in hospital this board is of the opinion that this man has no organic nervous disease but is a marked case of hysteria with arteriosclerosis." Physical findings were practically negative for a man of his age. There was apparent loss of sensation over entire body to pain, heat and cold, although a severe pin prick produces a slight involuntary withdrawal movement; and when the test was

made with patient asleep he awakened with a start, asking what was being done to him. There is apparent loss of stereognostic and posture senses but lack of coöperation jeopardizes these findings. Patient regularly complains of a sense of great weakness and loss of nearly all motor power. He would only partially flex his fingers in giving a hand grasp and declared that he had very little use of his hands and could not possibly undertake any sort of manual employment. His habitual occupation of filling and lighting his pipe he performed with great facility.

Knee jerks greatly exaggerated; ankle clonus present; gait pseudo-spastic; pupillary reflexes present but possibly slightly sluggish; skin reflexes active; no Babinski, Wassermann negative. When at rest there is no muscular tremor, but violent shaking is likely to follow manipulation or directed movements, and during examination is apparently unable to walk on account of shaking of his legs. When in the ward with other patients only, he shuffles about without difficulty.

In view of the fact that the disability arose during service, this man was re-attested and put on pay and allowance from the time of his discharge and admitted to the special hospital at Cobourg, April 3, 1917. Here it was impossible to secure his coöperation in any sort of employment. He maintained the attitude of great weakness and helplessness; his chief preoccupation was the pensionability of his disability; and inordinate selfishness was constantly in evidence. The comfort of his family never occupied his attention. He felt that their duty was to wait upon him, and when at home he was attended by his wife in every detail, with the exception of eating, and smoking his pipe.

The patient was very reticent about his past life and had misstated his age. He allowed it to be known, however, that he had previously been engaged in various lawsuits in which he had sued for damages. The subject upon which patient was freest in discussion was his disability and its symptoms.

Early involitional changes in the nervous system might possibly be invoked to account in part for the general attitude of inertia; but the conspicuous objective of all the patient's thought processes makes it appear suitable to designate his case as one of "pension-neurosis."

CASE 8.—*Hysteria*.—(Symptoms referred to cerebellar lesion). This unusual case occurred in a youth who enlisted in October, 1915, at the age of 14 years and 10 months. Being well grown and appearing several years older, he had given his age as 18. Two older brothers were already serving at the front. The father was reported to have been alcoholic.

After a year's training in Canada, while on transport going to England he states that he had some sort of a "spell" and struck his head. Soon after arrival in England he began to complain of dizziness and faintness while on parade. In January, 1917, he complained of severe intermittent pains in the back of the head. He also vomited several times.

In February, 1917, he was admitted to hospital, remaining ten weeks. His medical history sheet states: "Trehinied over cerebellar region left side, after having shown signs of cerebellar tumor. Condition very much relieved. *Very severe.*"

Patient was later admitted to the Granville Canadian Special Hospital, where in May, 1917, the neurologist in charge reported:

"Disability.—Pain in back of head and forgetfulness, following some, as far as history goes, indefinite cerebral disturbance which was diagnosed as cerebellar tumor, and for which he was operated upon and cerebellar decompression done February, 1917.

Present condition.—Has no sign at present of any organic lesion of the nervous system."

Eye grounds were negative; no nystagmus, no difficulty in walking; abdominal reflexes present; knee jerks present only on reinforcement; no Babinski.

On board ship returning to Canada in June, 1917, the medical officer recorded: "Violent pains in back of head; convulsive seizures somewhat Jacksonian in type on right side; periods of violence when he is dangerous to others about him."

The officer commanding the Hospital Ship noted: "He has caused a deal of trouble on the voyage and I am not convinced that his conduct is altogether due to a pathological condition. In any case, he will require careful observation."

After admission to Special Hospital in Canada, patient displayed a considerable variety of symptoms. There were intermittent periods of apparent stupor in which he was mute and

stared wide-eyed in one direction. For a few days he complained of extreme abdominal pains, associated with slight rise in temperature, which then passed off. His complaints had been such, however, that at first the advisability of operation was considered. The patient wanted much attention, and after reporting himself very ill would call for food; later, perhaps, announcing that he expected to die incontinently.

So far as the evidence goes it seems highly probable that the whole reaction has been hysterical from the first, complicated possibly by post-operative manifestations. The operation revealed no cause for the symptoms which, although in abeyance for a short time, recurred with as great severity as before it was done. The later access of abdominal pain probably associated with indigestion and gas formation, was the cause of equally aggravated complaints. The patient's whole reaction has been more or less juvenile and at times there has seemed to be no doubt of the voluntary assumption of symptoms, such as violent shaking and trembling and fixed stare. A grievance reaction also has not been lacking, the patient insisting on the rights of returned soldiers. When on parole and under observation he has sometimes begun to act in an erratic and apparently irresponsible manner, thus attracting attention and being brought in by escort.

About four months after return to Canada, he began settling down into a more orderly state and showed himself capable of fairly regular employment. He soon presented the picture of health in every respect.

CASE 9.—*Mythomania*.—This is a still more unusual case of a psychopathic personality showing traces of manic constitution and in which a fabrication tendency, also apparently constitutional, attained a gorgeous efflorescence during service.

This man enlisted in August, 1914, at the age of 24, and was found physically fit. He proceeded overseas with the first Canadian contingent.

The case can, perhaps, best be presented by submitting first some items from the patient's own account of his experiences, which were obtained from him in August, 1916, after which actual facts will be subjoined for comparison.

*Patient's Story*.—Leaving school at the age of 14, he wandered about the world. He has

been a promoter, a card sharper, a race track tout, a wrestler and trainer, and other things, in short, a first class adventurer, never lacking money long. "I used my head to make money." Variable alcoholic habits since the age of 17, and several Neisser infections (the last one in France), the patient admits as matters of course. Lues denied. As to his previous health he asserts that he was "like a horse."

Continuing the narrative, invalid arrived in England in October, 1914, and in France February, 1915. He was sent at once to the front where he saw active service more than five months.

About the 15th June, he had "a touch of gas" owing to the fact that his "respirator leaked." This laid him up in the hospital five or six days and he was never as good a man afterwards. As he expresses it, his "nerves were all shot to hell," this condition being due "not to being scared but sheer weakness." He describes his many experiences as a despatch rider, occupying most of his time in France. He would talk to his motor cycle as if it were alive and then fall to crying "with rage and weakness." He admitted various personal encounters with the enemy and allowed the inference to be drawn that he had various German dead to his credit. At the same time he protested that he preferred not to discuss these matters as he was naturally averse to saying or doing anything which savoured of display.

Finally, on the 19th July, he was pursued on his motor cycle by several of the enemy. He was blown up by a shell explosion, and his machine wrecked. For two weeks he was unconscious, and after that his self control, already much affected, was entirely gone. "I was like a kid three years old; my body had over-fought my will." He declared that the explosion had partly buried him, that his left chest and arm were severely bruised, two ribs fractured, his right foot injured. Invalid states that he was taken to England 12 days after the casualty. He complained of weakness and numbness in his left arm every morning, and that the cords of the neck were swollen; had a stinging pain through the head and ears and tightening across the chest; twitching of the face and jerking of the extremities; in fact, "a big irritation all through the system."

He gives the date of his return to Canada as November, 1915. Not before the following May did he begin to feel return of self control.

When the patient furnished the above account he was still complaining of the nervousness resulting from his experiences in France. There was moderate pyorrhoea alveolaris which he said was due to the gas attack. Physically, he was in good condition. There was some vaso-motor irritability and a tendency to perspire easily. Knee jerks were diminished. His general reaction was hypochondriacal and he reported numerous changeable paraesthesiae.

The *actual data* of this patient's service overseas are as follows: He was admitted to No. 1 General Hospital Netheravon, January 6, 1915, complaining of pain over his heart and in his left arm and shoulder. The condition was diagnosed as rheumatoid arthritis. The patient had given a history of a fall while in camp in Canada the preceding August, bruising his left chest and shoulder; and stated that he had injured himself again in England while unloading a transport wagon. The history showed that he had been reporting sick with pains in different parts of the body at frequent intervals practically ever since enlistment, and that he had had considerable treatment with indifferent results.

At the time in February, 1915, when the patient declared that he went to the front, he was really being boarded in England for discharge and return to Canada as medically unfit; and on February 20 he made a signed declaration that it was his wish to return to Canada.

The findings of the medical board were duly approved and the patient arrived in Halifax, March 23, 1915, and was discharged at once from the service.

In February, 1916, he reported at the convalescent hospital in his home town and applied for treatment. His account at this time was considerably at variance with the one first quoted above. He stated that he had been in France but never in the trenches; and that while there he was suffering so much from pain in the left arm that within about a week of arrival he was returned to England.

Then followed a series of letters from the patient to Militia Headquarters describing his symptoms and asking for reinstatement on pay. "I was one of the first boys to return from the first contingent unfit for further service . . . I feel that I am entitled to some assistance from you as I have given my

best for my country's cause and should have some consideration."

He was put back on pay and kept under treatment from February to December, 1916. He still complained of weakness and pain in the left arm. A medical board in November, 1916, reported: "The pain is probably psychic as no organic cause could be found. A cervical rib was suspected but repeated x-ray tests are negative. He is of a nervous temperament but apparently otherwise in good health."

In December, 1916, he was again discharged from the service with a small pension running six months.

In this case we have an excellent example of that form of delusion known as huntsman's Latin, which our patient had apparently found a convenient medium of intellectual exchange, and one well suited to his temperament. With his greatly exaggerated self-feel and self-sufficiency, his expressed sentiments of modesty were continually at odds, like the mock humility of the super-pious. An audience of uninitiated was his golden opportunity. He delighted in speaking at recruiting meetings and the prestige of the returned soldier who has been through it all, was dear to him. The war, he declared, had been a great education which he "wouldn't sell for ten thousand dollars." The pretense and artificiality in social life which he found at home on returning "from the front" filled him with aversion. It left him unsatisfied. It was the primitive savagery of army life that suited him. He felt the call of the trenches and would fain return.

The assurance and initiative required to turn the services of others to his own advantage were never lacking; they were even shamelessly conspicuous. When one day he found a dime on the floor, his instant instinctive exclamation was, "two beers."

Regarding the future he had no misgivings. He would "match his head against the other man's," and make his way. Singularly out of keeping seemed his somewhat pusillanimous complaints and solicitations before the authorities. Perhaps though the discrepancy was only apparent.

*Stereotyped Symptoms.*—There is a group of general symptoms common to practically all the war neuroses, so common, indeed, that if they were recorded together with a rubber stamp following the diagnosis of functional

neurosis there would be very few errors of description.

These stereotyped symptoms include a feeling of general weakness, disturbed sleep, headache and other pain reactions, dizziness or faintness, tremors often aggravated by observation, psychomotor irritability, complaint of dyspnoea and palpitation on exertion, vasomotor disturbances, difficulty in fixing attention and of sustained effort of any kind.

As neurosis cases improve it is rather striking that the symptoms last to disappear and which recur provokingly are those which being purely subjective in character cannot in any way be demonstrated. These are vague pain reactions, sense of weakness or malaise, dizziness, feeling of nervousness or restlessness, variable appetite, ringing in the ears, various paraesthesiae, etc. Months or years after the patient has returned from overseas and when physical examination fails to reveal anything abnormal, symptoms such as these may still be complained of as a basis of occupational incapacity. Occasionally a persistent tachycardia is the only objective finding.

*General Characteristics of War Neuroses.*—Viewing these conditions en masse we note the following features:

- (1) The preponderance of exogenic factors as compared with the neuroses of peace.
- (2) The wide prevalence of neurotic reactions at least in mild or transitory form among soldiers at the front, though not necessarily incapacitating for duty.
- (3) The distinctive reactive war coloring.
- (4) The frequent incidence of phases of trench neurosis masking for a time or modifying the course of actual mental disease.
- (5) The not uncommon association of neurotic symptoms with minor physical disabilities, giving to the latter an apparently aggravated character.
- (6) The almost universal occurrence of stereotyped symptoms; the conditions and associations of warfare constituting a real neurosis school.
- (7) The attitude of hospitality on the part of the invalid toward his neurosis or at least an air of resignation often suspiciously like satisfaction.
- (8) The stubbornness with which these neurotic habit reactions may persist as a result of the unique fixation motives underlying them.

*Predisposition to Nervous and Mental Disease.*—In the presence of such large numbers of nervous and mental invalids returning from the war the question of predisposition forces itself upon us as a vital one. What is the past history of these invalids? Could any of these breakdowns have been averted? How would these men have fared in civil life?

With these questions in mind, records of 2500 men returned with some form of nervous disability were examined. It was at once apparent that there were two big groups; namely those *with* and those *without* significant data as to the previous history of the individual. From the very character of the usual military records it does not follow that the absence of a specific statement regarding the man's previous health means that his health has been good. Moreover, we know that in the field of nervous disorders especially, the man's off-hand statement that he has always previously been well (which too often is the only information available), cannot be accepted as evidence. In many cases lacking earlier personal data in which special enquiry has been possible, positive findings as to predisposition or even pre-existence of the disability have been forthcoming. It results that our figures may be considered as minimal estimates, and that they would be considerably higher if fuller data were available.

Among 2500 cases, the records show pre-enlistment causes in 30%. The following table shows the respective percentage of the several types of disability in which such pre-enlistment causes were found:

PRE-ENLISTMENT CAUSES AMONG 2500 NERVOUS AND MENTAL CASES.

|                       |      |
|-----------------------|------|
| Neurological } .....  | 14%  |
| Miscellaneous } ..... | 14%  |
| Neuroses .....        | 18%  |
| Psychoses } .....     | 51%  |
| Defect States } ..... | 83%  |
| Epilepsy, etc. ....   | 83%  |
| Alcoholism            |      |
| Drug habit }          | 100% |
| Undesirables }        |      |

If there were the slightest question in the mind of anyone as to the need of a careful inspection of recruits from the viewpoint of their mental fitness, as well as physical, a perusal of these figures would supply the answer. It must be borne in mind that they refer essentially to earlier conditions in the Canadian service. There, as elsewhere, at the beginning of this war military fitness was practically

synonymous with physical fitness. To be sure some very general qualifications were indicated in instructions to medical officers; for example, that a man with epileptic history should not be accepted, and that recruits must be "sufficiently intelligent." Notwithstanding, in so far as any systematic attention to the mental state of the soldier was concerned, it may safely be said that mental unfitness as a cause of rejection was as good as unrecognized.

The two conspicuous classes in the above table are the psychosis and epilepsy groups. In 51% of the former and 83% of the latter the disease itself or definite predisposing factors demonstrably ante-dated enlistment. These two groups together accounted for about 950 of the 2500 cases; and of these 950, 480 had positive previous history (among the epileptics alone, 250 out of 300).

According to available figures the percentage of pre-enlistment causes is somewhat higher among nervous and mental disabilities than among physical. In a similar survey of 2000 invalids of all types the corresponding ratio was 25%.

It is obvious that war experience supports the diathesis factor in mental diseases, although the frequency of transitory psychotic episodes apparently reactive in nature might seem to point the other way. Of these conditions we can only say that, so far as our evidence goes, a given schizophrenic or cyclothymic constitution might never have broken down under the ordinary conditions of civil life; while under the stress of war such a constitution has been at a disadvantage and has given way to a mild or brief mental disturbance which the soldier of sounder stock might have escaped.

*The Shell Shock Tradition.*—This is one of the largest issues in connection with military medicine which has a non-medical and popular bearing as well. The diagnosis shell shock has been tremendously abused not only by making it include almost every nervous and mental condition arising at the front, even trifling or suspicious disabilities; but quite as much in its lay use both among the public at home and in the ranks of the army. Appendicitis was once the disease of the hour; later psychasthenia enjoyed this distinction; now it is shell shock.

Officially, the use of this diagnosis has been greatly restricted at the front. It should be still more limited among the home public. There is no reason to call a case shell shock

unless actual traumatic or physiological shock has been present. The resulting condition would then more properly be spoken of as a concussion syndrome.

With this diagnostic limitation we should probably rarely see in this country cases which could be described as shell shock, the concussion syndrome being, as a rule, a transitory one. Indeed with early and vigorous handling of all nervous conditions developing at the front, there should be fewer of the spectacular neuroses, such as hysterical paralysis, hysterical mutism and the like reaching these shores.

British, French and American authorities have taken the position that the great majority of war neuroses do not constitute discharge disabilities and are not conditions requiring prolonged treatment. In striking contrast with this view is the one too widely prevalent among the home public which accounts the war neurosis as one of the severer casualties dependent upon actual enduring injury of the central nervous system, and raises the disability to a plane of distinction.

While it is certainly true that in actual concussion and cases with general traumatism the central nervous tissue is likely to be involved, the changes which have been demonstrated are almost always transitory in character and can hardly be held responsible for neurotic habits which may succeed and persist for months or years. One of the most important aspects of the returned soldier problem for official consideration is the determining of a suitable public attitude toward war neuroses. With this type of case the tendency to hero worship is particularly likely to run rampant, is in effect most pernicious, and should be combated by every means possible. There should be no relaxation of military discipline so long as a case is under treatment. In so far as may be found necessary the public should be educated to keep hands off; and this applies with particular emphasis to benevolent women's committees.

**Prophylaxis.**—The most important means of preventing nervous breakdowns in the service is preventing obvious and probable candidates for such breakdowns from getting on the strength. This aspect of the question has, perhaps, been sufficiently emphasized. It is not anticipated that even the most thorough initial elimination of mentally unfit recruits would reduce to a negligible number the disabilities of

this type developing through stress of service. Nevertheless, it should very materially diminish the incidence of actual psychoses, cases of epilepsy and the mental disturbances associated with primary defect and the various character abnormalities. It should have even a considerable influence upon the frequency of occurrence of the war neuroses.

Another phase of the question has to do with the education and discipline of the troops in training. We are familiar with the harmful effects of mental contagion in the development of neurotic reactions. Prophylactic suggestion should work along the same lines, substituting in place of the popular tradition rational and salutary ideas as to the real nature of trench neurosis. A certain amount of advance knowledge of this kind skilfully disseminated among the ranks and backed up by a wholesome rigidity both in treatment and discipline will go far toward reducing the frequency and persistence of war neuroses.

**Malingering.**—This subject which has been left to the last, one hesitates to touch at all; and yet, avoid it as one may, it repeatedly thrusts itself forward. Charcot called hysteria "la grande simulatrice," and it is this particular characteristic which comes out most strikingly in neuroses among soldiers. Most authorities are on record as saying that malingering in the strict sense is very rare, but it must be remembered that the sense in which they understand it is very strict indeed. At the opposite extreme would, perhaps, be the viewpoint of many a philistine medical board, from which we should doubtless come to the conclusion that simulation in one form or another is very common indeed.

To set the matter right scientifically we may take the recognized standpoint that there are two situations. On the one hand, there is a conscious attempt to deceive others; this is malingering. On the other, the individual is the unconscious victim of self deception; this is auto-suggestion or neurosis. Such a distinction is probably scientifically justifiable. It is, moreover, morally admirable; but it is also practically difficult, and sometimes, one is tempted to add, pragmatically questionable. Furthermore, it must be realized that we are without methods of examination which will determine beyond peradventure that a given case is definitely and exclusively one thing and not the other, either straight malingering

or straight neurosis. We are more comfortable in compromising somewhat short of the scientific ideal; and in a great many cases common sense will be likely to suspect that it discerns a subtle admixture of both types of suggestion. The stage in which a case comes under observation may also be significant. It is not unknown that what may be at first a more or less voluntary assumption of an abnormal reaction may later, as a formed habit, become an actual factor of auto-suggestion. On the other hand, we are equally familiar with true mental disabilities of depressive type in which the patients themselves believe and even declare that they are guilty of simulation in the display of their symptoms.

In any case by turning suspects over for careful mental examination, giving them for the time being the benefit of the doubt but no immunity beyond that justified by reasonable doubt, and by an uncompromising application of the measures of treatment and discipline as in all neuroses, the problem of malingering may be expected to give rise to less and less difficulty.

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### Society Report.

#### ABSTRACT OF THE PROCEEDINGS OF THE FORTIETH ANNUAL CONGRESS OF THE AMERICAN LARYNGOLOG- ICAL ASSOCIATION, HELD AT AT- LANTIC CITY, NEW JERSEY, MAY 27. 29, 1918.

(Continued from page 587.)

##### REPORT OF A CASE OF PROLONGED INTUBATION.

EMIL MAYER, M.D., NEW YORK CITY.

A boy aged nine years had had diphtheria at the age of two, for which tracheotomy was done, resulting in a tracheal fistula, for which he was admitted to the hospital. Attempts to close this by plastic operation failed, with the result that a tracheotomy tube had to be inserted.

Stenosis of the larynx followed, which was treated by division, with subsequent introduction of an intubation tube. This tube had to be removed under suspension and promptly reinserted at intervals for a period of five years, always under general anesthesia. Finally, in April, 1918, the intubation tube was removed. A tracheotomy tube was inserted for a couple

of days. This was removed, the wound closed, the patient breathing since through the natural passages. The writer concludes:

The special points of interest in this case are:

1. Persistent remaining of a tracheal fistula in spite of every faithful attempt at its closure.
2. A stenosis of the lower portion of the larynx, due to contraction of the natural parts, and their consequent disuse.
3. The impossibility of intubating except under general anesthesia and under suspension.
4. Persistent collapse of the larynx as soon as extubated.
5. The prolonged wearing for five years of an intubation tube.
6. The ability to breathe through the natural passages after all these years, in spite of the loss of at least two anterior rings of the trachea.

To this happy outcome must be attributed, in great extent, the growth of the patient, who, from a little boy of nine, and four feet in height, is now nearly fifteen years old, and has attained a height of five feet five inches, with natural increase in size of all his organs, including the trachea and larynx.

##### DISCUSSION.

DR. HENRY L. SWAIN, New Haven: I should like to inquire as to the development of thyroid and cricoid cartilage, notwithstanding their disuse—do they grow in the normal way?

Answer: Yes.

DR. JOSEPH H. BRYAN, Washington: It must have taken long continued, patient work.

DR. THOMAS H. HALSTED, Syracuse: I hoped that Dr. Mayer would help me out on a case that is at present under my care. Three months ago I was called to see a child a year old which had had a mild laryngitis for several days. A general physician was in charge of the case. One night the dyspnea became worse, and I was called in. I found the child cyanosed and the dyspnea very great. Examination revealed nothing. I had the child sent to the hospital, and went there myself in my car, after telephoning for them to have the instruments ready for immediate intubation. The tube was put in immediately and a culture was made and found negative. Antitoxin was given on general principles. At the end of six days, I removed the tube, but had to put it

back immediately and make artificial respiration. We gave this child antitoxin during the first few days. The throat was examined repeatedly, but the culture was always negative. It has been three months now, and during this time I have extubated eight times and intubated nine times. I did a direct laryngoscopy a month ago, and found nothing but an ashy appearance of the trachea, resembling a pseudomembrane. I did not do a bronchoscopy. We suspected the existence of a foreign body, and the child has been x-rayed several times, always without result. The child is perfectly well otherwise, and has gained in weight. It walks about and enjoys itself, and has no difficulty in swallowing, but I do not know how to get rid of the tube. The grandmother wants me to say that she believes that it was all due to teething. I do not know. The child has had one very slowly erupting tooth, one of the molars. It has been exceedingly painful. It has taken that tooth, which looked as if it were ready to erupt when the thing happened, until now to come through, and in the meanwhile a number of other teeth have erupted.

DR. CHARLES W. RICHARDSON, Washington: The case of Dr. Mayer's is a very interesting one. In former days, when I did a great many intubations, I occasionally met with some prolonged retention of the tube, but I think that Dr. Mayer has the record for long retention of the tube, and I wish to congratulate him on surmounting his various difficulties, especially after the loss of part of the cartilage.

May I ask whether he does not think that there was some regeneration of the cartilage later on, which caused the box of the larynx to stiffen up so that its firmness made it possible for him eventually to take out the tube and dispense with it entirely? That seems to me to have occurred in this case.

Regarding Dr. Halsted's case: Some few years ago I reported a series of cases of laryngitis hypertrophica subglottica acuta, and I should judge from what he describes that it was a case absolutely of the same character. Such is the usual history of these cases, as he describes and as I have seen them. They are usually very intractable with regard to the removal of the tube. They have in the past given me more trouble than the fewer retained tubes in diphtheritic cases, as you would naturally expect on account of the fact that the primary trouble in these cases is subglottic in the cri-

oid region. Of course, when I took out the tube in these retained cases the stenosis immediately recurred or soon thereafter. It takes some time to get rid of the tube. I should not worry about it, but keep on in the same way he is now following. I have had cases last three or four months before eventually being able to dispense with the tube.

DR. HENRY L. SWAIN, New Haven: I presume that Dr. Halsted adopted the method of giving large doses of an anti-spasmodic before attempting to take the tube out. That is often successful. You can then remove it, when you would not be able to do so if the child was in possession of all his reflexes. I have had exactly the same kind of case as Dr. Halsted. In fact, there are three in the hospital now. One is just like this, and the others are retained tube cases. I have had trouble to get rid of them. I am sorry that I forgot Dr. Richardson's suggestion, and I think that this explains the situation perfectly. However, I did try to look upward in one of the cases. I was called in consultation and thought that it would be a good thing to do a tracheotomy and take the tube out. At the time of the operation and later, I tried to look in from below and see the condition of the larynx and find out what its interior contained, but without success. Some time after the tracheotomy this child had a sudden choking fit and died. We could not explain the matter, unless it was general uremia. The other children got well, but in these we had almost to stupefy the patient before we could get the tube out and have it stay out. In one case we had to keep the child under the narcotic for a whole twenty-four hours. These two children are all right now.

DR. EMIL MAYER, New York City, closing: Replying to Dr. Richardson's question, I would say that perhaps there was not so much reformation of cartilage, but that on account of the long-continued presence of the tube all the tissues about the trachea became as hard as whipsnads. So we had almost bony ridges on each side, which served to prevent the collapse that surely would have occurred from the falling in of the soft parts.

Regarding the case that the chairman presented, it does seem that an acute laryngotracheitis of some kind was the original cause requiring intubation. Dr. Lynah, in a masterly paper on "Prolonged Wearing of Intubation Tubes," recently called attention to the imme-

diate collapse that takes place in many instances when the tube has been removed, requiring a hasty reintubation. In fact, he tells of a case in a boy who was extubated and returned to the ward. The boy was under the impression that the tube was still *in situ*. He was kept in the hospital for some time, and every time he misbehaved they threatened to remove the tube, and he immediately behaved. The tube was not there, but he thought it was. I would suggest to Dr. Halsted to introduce a much larger intubation tube next time, and when he does extubate to have the patient under some opiate, so that the general reflexes would cease, watching over him for that time of immediate danger and the likelihood of having to do a tracheotomy.

Regarding the question of Dr. Swain, as to whether the patient did not receive quantities of antispasmodics, I would say that the boy was never extubated except under general anesthesia. He has been receiving an eighth of a grain of morphia, and then being completely anesthetized while the tube was removed for cleansing, and this latter had to be done in a hurry. He has been anesthetized over twenty-five times, and each time the anesthesia became more difficult because he was pretty well soaked with the drug. I hope that we shall not have to do any more for the little chap because he has been very brave. It certainly was to me a most interesting case, and one of the most important deductions that we can make is the wonderful tolerance of the larynx. The keeping of a tube in a larynx for a month's time seems to make no difference to him.

#### THE SURGERY OF LARYNGEAL MALIGNANCY.

HUBERT ARROWSMITH, M.D., BROOKLYN.

From the author's observations of MacKenty's work and his own recent experience, modeled very closely thereon, he is inclined tentatively to suggest the adoption of Moure's antecedent tracheotomy, to accustom the lower air passages to the direct impact of air, which may lessen their immediate postoperative irritability and susceptibility; the tracheal opening to be made high, as Jackson has indicated, because that will not interfere with the later mobilization of the trachea. Otherwise the two-step operation seems to offer no special advantage. This is the ideal field for the employment of oil-ether colonic anesthesia, as de-

vised by Gwathmey. It makes the whole procedure infinitely easier for both patient and operator. Even if really painless under local anesthesia, such an ordeal produces an enormous apprehension which cannot but be detrimental to the patient, and the degree of infiltration of the tissues necessary to produce insensitiveness must interfere with their repair. With rectal anesthesia laryngeal spasm does not occur, bleeding is very much less, there is no tracheo-bronchial irritation from the directly inspired anesthetic, which very largely obviates the necessity for subsequent repeated applications of the suction apparatus—in itself an agent of some danger—and there is much less likelihood of postoperative vomiting, most undesirable under these conditions.

The laryngologist for every possible reason is the man who should do laryngeal surgery, both external and internal. If he saw all these patients at an early date, thyrotomy would more often be performed.

Laryngectomy cannot be repudiated on any such grounds as the mutilation, or the loss of voice. Laryngectomized patients are in no worse case than the blind, the deaf or the helplessly crippled. Many of them seem to get a fair amount of happiness out of the mere fact of existence, and are not by any means incapable of self-support. In judiciously chosen cases this operation offers a good deal more than a probability of clinical cure, and in most instances a definite retardation of the fatal ending.

Of two cases operated by the writer, one died six weeks later of pneumonia. The other is in good condition, now six months after operation, and at work.

A third case, in whom only a tracheotomy was done, his final sufferings were so great that the author regrets that he did not give the patient "a fighting chance by as far-reaching a dissection as possible," rather than witness such sufferings as this man endured during the last six months of his life.

#### DISCUSSION.

DR. JOHN E. MACKENTY, New York City: The main trouble is that the cases come to us too late for any hope of permanent cure. Of twenty-three cases seen by me since last September, seventeen were inoperable, except in the way of alleviation. Only one case of the twenty-three was incipient. Now, that is a ter-

rible commentary on the present condition of the diagnosis of this disease. There is fault somewhere, and, as Dr. Arrowsmith says, I think it is largely with the general practitioner, who does not take notice of the early symptoms. Anyone of cancer age complaining of hoarseness which lasts for more than six weeks should be under observation. There is no question that the mortality has decreased during the last few years. Up to seven or eight years ago it was very high. At the present day, those taking this work up have a different experience, and find the operative mortality much lower. I think that care in the technic will reduce the operative mortality to a very small fraction.

Partial laryngectomy is a seldom required operation. I have added no cases of this procedure to the former record. I have seen none requiring it. Besides, hemilaryngectomy is more dangerous as an operative procedure than total laryngectomy. I think that a lot depends on getting the cases over the surgical end of it, on the postoperative treatment, more than we realize; it is the neglect of the small details following operation that produces the mortality.

I am wedded to the one-stage operation, but I am not prejudiced, I hope, and see some reason now in the use of the high tracheotomy that does not in any way injure the trachea. I object to the other because it injures the trachea.

I have been impressed by Dr. Arrowsmith's exhibition of colonic anesthesia. Having seen it used in this type of operation, I am going to give it a thorough trial. I believe that in colonic anesthesia we have made an advance in this work, because it lessens the amount of hemorrhage and of blood getting into the trachea, which I consider very important in guarding the patient against pneumonia.

DR. CORNELIUS G. COAKLEY, New York City: It would seem to me that a one-stage operation is, in some cases, much to be preferred to a two-stage operation. If the growth is small, and you can afford to wait for the adjustment of the respiratory tract to the new method of breathing, all right; but if the case is likely to result in total laryngectomy the one-stage operation is to be preferred.

DR. ROSEAR CLYDE LYNCH, New Orleans: I have now six cases of intrinsic carcinoma of the larynx that I have operated on under suspension. Four of these patients are perfectly

well at the present time. In the remotest case, it has been four years since the time of operation; in the most recent, about eight months. So far, there has been no recurrence, but I want to be sure that you understand that it is not good advice to give you at this time to operate on cases of intrinsic carcinoma of the larynx by that means. I am afraid that some men might think that this is an operation of choice and do it, and thus do more harm than good. In the second place, it would seem to me that as we progress along the line of study of operation for carcinoma of the larynx, the operations are going to divide themselves into two types—the thyroidotomy and the laryngectomy types. The cases requiring hemilaryngectomy will, very likely, give much better results under total laryngectomy. I have had seven cases with five cures and no immediate deaths, within ten days from the operation. The recurrence taking place within ten months is the shortest time. That is, the patients who got the least benefit from the laryngectomy lived ten months, and in this particular case he was especially grateful for this added period to his life, in order to wind up his affairs so that he might leave them in shape for his family. Five of these patients are perfectly well up until the present time. Three of them are farmers who have been through three crops. That is, they have planted and harvested their crops three times, and their families have been provided for by that means. The others are clerks, and all are particularly happy and grateful. All can do without pad and pencil, in that they have been able to develop a type of speech that is understandable by their associates.

My procedure has always been by means of a preliminary tracheotomy, and at first low down, but now high up. I have not seen any cases in which the tumors have grown so large within two or three weeks following the tracheotomy as to make me feel that the tracheotomy itself had jeopardized the patient's welfare as far as his recovery was concerned. Giving always the ether vapor anesthesia, and giving the vapor through the tracheotomy tube has certainly facilitated every manipulation during the operative procedure. I now take away with the larynx the superficial thyroid muscles, the sternothyroid and sternohyoid, that group of muscles overlying the anterior face of the larynx.

I first started rectal feeding after the operation, but that has been supplanted by the use of the nasal tube or the introduction of the small catheter, just as one would do with a stomach tube, keeping the end of the catheter out of the stomach; that is important, in order to get away from the nausea or postfeeding vomiting. The tube should be inserted down to the neck, so that the esophagus may take care of the swallowing to the stomach.

The method of the care of the trachea, to me, has seemed very important. I part the trachea and larynx, and attempt to separate at one point the trachea from the esophagus, and then I put in a tape, so that I may hold the trachea up until it is bent in that fashion. When things are ready I cut the trachea from above down, and the only bleeding that occurs is from the mucous membrane of the trachea. Before the trachea is cut a heavy silk suture is put in and held by an assistant. This prevents any blood from going down into the trachea. The anesthesia is carried on through a very small tracheotomy tube, which lies in the opening, and is also under the care of the assistant, who steadies the trachea. He has nothing to do but be sure that nothing enters the trachea. I do not know whether that is what keeps us from pneumonia or not, but we had no postoperative disturbance, and the remarkable gain in weight and the comfort that these people enjoy after the removal of the mass make it well worth while. It does seem to me that laryngectomy is not nearly so bad a thing for the patient as one would gather from reading the older articles on these subjects.

DR. HARMON SMITH, New York City: The reader of the paper cited a report of a case made by me. Last week I saw the woman. Her voice has returned, and she has gained in weight, although that was not necessary, as she weighed two hundred pounds to begin with. I believe that it was of low-grade malignancy, of a papilloma carcinomatous variety.

DR. D. BRYSON DELAVAN, New York City: Yesterday morning I exhibited to a number of members of the society a patient who had been operated on by a friend of mine in New York City twenty-one years ago, two-thirds of the larynx being removed, and he is perfectly well today. That is one of the few cases followed and the end-results studied.

DR. HUBERT ARROWSMITH, Brooklyn, closing: The plea I make is one of the utmost impor-

tance. If we are going to reach conclusions we want to know what becomes of the patient. Perhaps we do not all realize that our distinguished honorary president, Dr. Solis Cohen, was the originator of this method of handling the stump of the trachea, an invaluable step in the after-treatment of laryngectomy, and I think he was the first to do a laryngectomy in America.

DR. J. SOLIS COHEN, Philadelphia: I was not the first to do a laryngectomy, but the first to report the case.

(To be continued.)

#### American Medical Biographies.

##### MANN, JAMES (1759-1832).\*

THIS army surgeon, who served three years in the Revolution and another three years in the War of 1812, thirty years later, and wrote most interestingly of military medical problems, was born in Wrentham, Massachusetts, July 22, 1759. After graduating in arts from Harvard College in 1776, in the same class with Aaron Dexter, he became a pupil in medicine, as was the custom of the day, with Dr. Samuel Danforth, a leading practitioner of Boston, and at the age of twenty became a surgeon to Colonel Shepard's 4th Massachusetts Regiment, July 1, 1779. He was reported a prisoner of war in June, 1781, and was imprisoned on Long Island in July and August of that year. Because of failing health he resigned from the service April 14, 1782, and settled in practice in his native town, and this year Yale conferred on him her honorary A.M., and Brown did the same in 1783. We hear of him next, April 13, 1791, when the records of the Massachusetts Medical Society inform us that "a letter from Doctor James Mann of Wrentham on Diabetes was received and read." He joined that medical society in the year of its reorganization, 1803, and published in the second volume of its Medical Communications papers on "Observations on the Lymphatic Swelling of the Inferior Extremities of Puerperal Women" and "Observations upon Menorrhagia and Leucorrhea and the Beneficent Employment of Blisters, Acetate of Lead, and the Submuriate of Mercury in

\* From the forthcoming "American Medical Biography" by Dr. Howard A. Kelly and Dr. Walter L. Barrage. Any important additions or corrections will be welcomed by the authors.

those Diseases." He gained the Boylston Prize, December 31, 1806, by a dissertation on Dysentery. During the rebellion in Western Massachusetts in 1786-87, that was called Shay's Rebellion, Dr. Mann was ordered to visit the militia camps and report to General William Shepard.

Previous to 1812 he practised in New York, and on the opening of war joined the United States Army as hospital surgeon and was afterwards head of the medical staff of General Dearborn's Army, which was stationed on the Canadian frontier in Northern New York. He was present at the battle of Plattsburgh, and had charge of the wounded on that memorable day. He was invited to lecture on the theory and practice of physic at the Fairfield Medical School, Herkimer County, New York, but was obliged to decline because of his army duties. Brown University gave him her honorary M.D. in 1815. After peace was declared Dr. Mann became post-surgeon (April, 1818), and assistant surgeon (May, 1821). His chief writing was published in Dedham, Mass., in 1816,—a book of 318 pages, entitled "Medical Sketches of the Campaigns of 1812, '13, '14, to which are added surgical cases, observations on military hospitals attached to a moving army, also an appendix with a dissertation on the dysentery of 1806 and the winter epidemic in Sharon and Rochester, Mass., of peripneumonia notata in 1815-16." This book gives a vivid picture of army life, of the medical questions that had to be solved, and of the surgeons with whom he came into touch, but unfortunately the book casts too little light on the personality of the writer.

After the war Dr. Mann was elected consulting physician to the Massachusetts General Hospital in Boston, in place of Dr. Danforth, but there is no record that he rendered any service in that capacity, and in 1821 he was made chairman of a committee of five of the Massachusetts Medical Society "to report on what measures could be adopted to secure a better education of those persons who undertake to compound, put up or sell medicines in conformity with the prescriptions of physicians." The committee reported to the council in October of that year, and the report was adopted. It was about this time that he did a successful amputation at the elbow joint, reporting it in the *Medical Repository*, New

York, 1822, xxii, 14-20 under the title, "Observations on Amputations at the Joints."

Dr. Mann became a member of the Society of the Cincinnati and of the American Academy of Arts and Sciences; he did not return to private practice but remained and died in the public service, being stationed at Governor's Island, New York Harbor, when the end came, November 7, 1832.

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WALTER L. BURRAGE, M.D.

#### Book Reviews.

*A Textbook of Nervous Diseases.* By ROBERT BING, Docent for Neurology at the University of Basel. Authorized translation by CHARLES L. ALLEN, M.D. New York: Rebman Company. 1916.

A textbook on nervous diseases by Dr. Bing is well deserving of attention, for his well known book on the topographical diagnosis of diseases of the brain and spinal cord has proved his skill as a teacher to present clearly and yet briefly a subject which is intricate and, as usually taught, confusing to students. In this book, as one would expect, the portions having to do with localization of lesions of the nervous system are clear and adequate though condensed. The grouping of the diseases has the advantage also of avoiding a good deal of repetition, as for example, in treating the subject of syphilis of the central nervous system, that of transverse lesions of the cord, and the disturbances of the endocrine glands. Tumor of the brain, even in a book on the plan of this one, deserves rather more space than the writer has given it.

The psychoneuroses are described adequately and clearly, though the newer classifications so much used of late as of anxiety neurosis, psychasthenia, and others, are not used, but the disturbances are included under the rather large group of forms of neurasthenia, though they are better differentiated from this disease and the name used for the type of fatigue neurosis.

Particularly because of the lucid and excellent treatment of the anatomical diagnosis of the various diseases of the nervous system we know of few books better adapted to the use of students when first approaching the study of these diseases.

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### FRENCH SYSTEM FOR RETURN TO CIVILIAN LIFE OF CRIPPLED SOLDIERS.

THE Red Cross Institute for Crippled and Disabled Men has recently issued a most interesting pamphlet, written by John L. Todd, Major, Canadian Army Medical Corps, on the subject of the French system for Return to Civilian Life of Crippled and Discharged Soldiers. The French have struggled with this problem, and the pamphlet summarizes their conclusions as to the best way to handle the many difficulties incurred, and suggests that many of the French ideas may be used to advantage in Canada.

Definite principles have governed the creation and design of measures adopted by France in caring for her discharged soldiers and sailors. France, with her whole strength, is fighting a national war; for that reason, the detriments incurred by Frenchmen are to be distributed, as equally as possible, among the citizens who compose France.

To secure the equitable return to civilian life of ex-soldiers and ex-sailors who have suffered physical or mental detriment, as a result of their service, is a work of large dimensions. Like every other large undertaking, it can be accomplished best under the administrative control of a single central directing body, by numerous executive agencies, each closely connected with the field of its operations. The need for a central administrative body has been recognized, and partly met; it is probable that it will be completely met.

In the organization of the executive agencies, it is to be remembered that the rehabilitation of disabled men is, in great part, a temporary operation, and that permanent machinery should not be created for effecting it unless a permanent use for that machinery exists; therefore, existing institutions and public services are employed whenever possible in executing the various operations by which disabled men are cared for.

While it has been, and will be, necessary to profit by the operation of important works of private benevolence, laws are about to be made which will prevent the initiation of unsound measures by irresponsible organizations dependent for funds upon private subscriptions. Private benevolence, indeed, should find no place in providing the advantages which disabled men should receive as a right from their fellow-citizens.

The interest of the men has been the first consideration in the designing of the methods adopted for returning discharged soldiers and sailors to civilian life; all measures have been designed with the object of returning the men in the best and quickest manner to an independent position in civilian life.

The procedure by which the rehabilitation of disabled men is effected may be divided conveniently into five stages:

1. Active medical and surgical treatment.
2. Functional reeducation.
3. The provision of artificial appliances.
4. Professional reeducation (vocational training).
5. Establishment in civilian life.

This division is, in a sense, an artificial one; since treatment, functional and professional reeducation, and the provision of artificial appliances are complementary processes. They should all be carried out as early as possible in the

progress of a patient; they will often be performed simultaneously. Consequently, they can best be carried out either in a single institution, or in special institutions closely allied in space and organization.

Such an institution, or group of institutions, is called a "center of reeducation." Many centers have been established in France; those at Saint-Maurice and at Bordeaux have been organized as models. It is estimated that about 30 to 40 per cent. of the men composing the French army will be admitted to hospitals because of disease or wounds. Active medical and surgical treatment is given to soldiers by the French Medical Service, in a host of hospitals. In addition to general hospitals, institutions for special purposes, such as the treatment of skin diseases or for the repair of injuries to the teeth and jaws, have been established by the medical service when and where they have been required. Among the most important of the special hospitals are the orthopedic centers. These are equipped with the staff and appliances necessary for performing any secondary operations of a special nature which may be necessary, and for undertaking functional reeducation. At these hospitals, the stump of every patient who has suffered an amputation is radiographed on admission, to see whether an appliance is as yet advisable. If the stump is in condition to bear an appliance, it is fitted with one, and the functional reeducation is begun. Under the term of functional reeducation are found all of the means adopted to secure the existence of a maximum of its normal function to an injured part. This is done by means of various exercises, gymnastics, and by light work, such as the making of bags or the hemming of towels. Work has been found to be most useful in functional reeducation, as it creates a hopeful outlook for the wounded man, and gives an opportunity of observing the patient's aptitudes, and so facilitates the making of a choice of an occupation for him.

The responsibility for controlling the treatment received by a soldier or sailor rests with the medical service of the army or the navy, until the soldier or sailor concerned is discharged, which does not usually take place until their functional reeducation is complete, and until they have received any artificial appliances which they may require. It is possi-

ble that, in the future, regulations will make it necessary for men requiring it to accept not only medical and surgical treatment but also professional reeducation.

The responsibility of recommending the discharge of a man as medically unfit for service rests with carefully-instructed, competent, and perfectly equipped boards composed of medical officers belonging to and appointed by the French Army Medical Service. These boards have also the responsibility, both of deciding whether a disability results from service—and is therefore pensionable—and of deciding the degree of incapacity resulting from a pensionable disability. The pension awarded in respect of a disability varies directly with the degree of incapacity resulting from it.

It has been accepted as a principle, first, that each man requiring an artificial appliance is to receive the appliance, of the best possible type, best suited to his needs; and, secondly, that artificial appliances supplied by the government are to be maintained in repair and replaced, when necessary, by the government.

An orthopedic commission has been appointed for the purpose of establishing the types of artificial appliances to be provided by the government. It is possible that the maintenance of appliances will be provided for by paying an annual sum for their repair to those using them.

The choice of a future occupation for a disabled man is a matter of the greatest importance. It can be made, rightly, only by those who have a special competence in such matters, who are accustomed to estimate a man's aptitudes, and have a knowledge of existing or probable opportunities for occupation.

It has been accepted as a principle that the economic soundness of measures connected with the establishment of disabled men in civilian life must never be allowed to depend upon any feeling of beneficence toward them. The position of a disabled soldier must be an assured one and dependent in no way upon the goodwill or assistance of others.

One industry in which official foresight is placing many disabled men is the manufacture of orthopedic appliances. The existence in France of perhaps fifty thousand men who will wear, and will require repairs for, prosthetic appliances of various sorts gives an opportunity for the creation of an important new industry. An artificial limb must usually be renewed at

the end of a few years; in the meantime it requires repairs. That the manufacture of artificial limbs is a profitable industry is evident from the fact that they are sold, at the current prices—between 200 and 250 francs for an artificial arm—for about three times the cost of their production. Considerable numbers of men are being trained as manufacturing orthopedists at the centers of reeducation, and it is well that this is so, if France is to keep the supply of artificial limbs for her wounded in her own hands, because, already, German manufacturers of artificial limbs are sending out circulars touting for business in France!

The Government fully appreciates that France is, after all, an agricultural country, and it is doing everything possible to direct discharged soldiers to occupations connected with the cultivation of the soil. Soldiers who, after a course of reeducation, are ready to assume their chosen positions in civilian life will frequently require assistance in order that they may be established, ready for work, in their workshops or on their farms. The artisan will require tools, materials, and money to secure his subsistence until his business is established; similarly, the farmer will require help in purchasing live stock, tools, and seeds before he can begin the cultivation of his land. As a rule, those who have passed through a center of reeducation will not require so much assistance as those who have not done so. It is part of the policy of most centers to assist their pupils to earn and to save money, so that they may have a small capital when they leave. In addition, some schools give their graduates an outfit of tools. It has been proposed that a special bank should be created for the purpose of providing financial assistance for men who require it on reentering civilian life.

There will inevitably be a comparatively small number of discharged soldiers who, although receiving pensions, will be incapable of looking after themselves entirely. It is the policy to allow men of this sort to be cared for, as much as possible, in the families of their relations or friends; their pension will be sufficient to bear the cost of their maintenance. Consequently, although institutional treatment may be necessary for some violent maniacs, etc.,—there will be no necessity for the establishment of old soldiers' homes. Indeed, it is anticipated, were such homes established, that there would be few men who would consent

to enter them. The vast majority of the present armies are men accustomed to home life; the soldiers for whom a past generation established "homes," like the "Invalides," were professional soldiers who had spent most of their lives in the barracks and had never had a home of their own.

The following are important matters connected with the establishment of ex-soldiers and ex-sailors in civilian life:

1. Provision of pensions.
2. Assistance to employment.
3. Advancement of capital.
4. Increased cost of insurance.
5. Settlement on the land.
6. Watching the interests of disabled men.

The old pension laws, which existed before the commencement of the war, have been found to be inadequate. It is certain that they will be replaced with new laws.

The principles which the laws, finally adopted, will observe are definite. A totally disabled man must receive a pension permitting him to support his family in decency. Only the extent of the incapacity resulting from an injury determines the grade of a pension; neither social rank, nor earning powers, nor any other factor but the extent of the incapacity is considered. In order to assist medical officers in estimating the extent of the incapacity resulting from a given disability, a guide, a disability table, has been prepared for their use; it has been found to be indispensable. A disability is pensionable only in the extent to which it is due to, or aggravated by, military service. While, in theory, a soldier has the right to refuse an operation involving the shedding of blood; in practice, an unreasonable refusal to submit to an operation which would result in the lessening of a disability is held to be sufficient reason for the reduction of the pension to the amount which would be awardable were the existing disability diminished by operation. Pensions granted in respect of a disability are the inalienable property of the grantee. They are paid quarterly and can be drawn upon, in advance, through the post offices.

Offices established by the Government will assist disabled men to find employment in every part of France. Laws have been framed providing that disabled men, other things being equal, should be given preference over other

applicants; for employment in Government service and in any enterprise governmental concessions or assistance.

In order to provide for the support of the families of men who, perhaps for a period of from one to two years, are receiving professional reeducation, the Government either continues to pay the separation allowance or pays the pension, whichever may be the greater. After reeducation has been completed, financial assistance for himself and his family will be required until the reeducated man can establish himself in his chosen trade.

It is recognized that accident insurance and life insurance, as a rule, must cost more for disabled men than for those who are sound. The principle has been recognized that, when the disability is due to military service, the increased cost of insurance would be borne, up to a certain amount, by the State. Up to the present, no procedure for relieving disabled men from the increased cost of life insurance has been made. A proposal to pay the increased cost of accident insurance from a fund contributed to by employers and by insurance companies will probably be adopted.

The desirability of settling disabled men on the land has been recognized and various laws have been proposed with the object of making it easy for them to acquire rural property.

It has been proposed in France that the Central Body, which administers matters connected with the return of ex-soldiers and ex-sailors to civilian life, shall exercise a general watch over ex-soldiers' and ex-sailors' interest. It has been recognized as most important that the general public should have a clear perception of the precise conditions in which ex-soldiers and ex-sailors will return to civil life, and no pains have been spared to spread information on this subject.

Another pamphlet, compiled in connection with the preceding one, is that on the Statistical Consideration of the Number of Men Crippled in War and Disabled in Industry, written by I. M. Rubinow. It is written to aid in the estimation of how many invalids are likely to be created by the war, and to help to make clear, out of the hazy data which now exists, the number of cripples whom we must provide for, after the war. Although it is not possible to make any exact estimate, by means of available statistics on the proportion of

battle losses caused by rifle and artillery fire in previous wars, and in this war, as learned from statistics concerning German wounded, and from estimates of the number of killed, wounded, and permanently disabled in the armies of the Central Powers and the Allies for the first two years of the war, conclusions well worth considering have been reached.

The pamphlet further estimates the number of persons disabled in industry, describes the Birmingham Enquiry, and gives statistics concerning the economic capacity of cripples.

#### MEDICAL NOTES.

MORE AID FOR HALIFAX.—The sum of \$250,000, representing the balance of \$1,000,000 contributed by the people of Massachusetts last winter for the relief of the victims of the Halifax explosion, will in all likelihood be devoted to combating tuberculosis and other forms of disease contracted by the sufferers. The relief work will be extended over a period of five years. This action was taken on the recommendation of Dr. Victor G. Heiser, director for the East of the Rockefeller Foundation, who was requested by Mr. Endicott chairman of the Massachusetts-Halifax Relief Committee, to make an investigation. Already relief representing an outlay of \$650,000 has been expended by people of the State. Already dwellings to the number of several hundreds have been erected for the shelter of the homeless and eighteen hundred persons have been provided with furnishings for their homes. The care of the blind has been instituted and pensions for the physically disabled have been established. The improvements and readjustments in public health conditions are necessary and are being arranged for as quickly as possible. The annual expenditures of the program are apportioned as follows: Massachusetts-Halifax Relief Committee, \$50,000; Canadian Government Halifax Relief Commission, \$15,000; Province of Nova Scotia and the City of Halifax, at least \$10,000.

#### WAR NOTES.

ARMY AND NAVY MEDICAL CORPS.—Applicants for the Medical Corps of the Army should make application either to Capt. John

T. Bottomley, 165 Beacon Street, Boston, or to Capt. Philip Kilroy, 61 Chestnut Street, Springfield. The examiners have application blanks, and will communicate all details as to membership in the Corps. Applicants for the Medical Corps of the Navy should apply to Capt. John M. Edgar, Naval Aid Department, Little Building, 80 Boylston Street, Boston. Capt. Edgar has the application blanks, and will give full information as to the requirements and the physical examination.

**PRAISES WORK OF SURGEONS.**—Dr. Warren Eastman, past assistant surgeon of the United States Navy, who was rescued from the torpedoed transport *Mt. Vernon*, gave an interesting narrative on his arrival in Lynn, of the wonderful work done by the surgeons in France on leg and arm surgery and surgery of the face. He said that there are 700 patients at the Val de Grace Hospital upon whom Dr. Morestin works, and is doing more than any one man for the mutilated soldier. The patience and time spent in saving legs and arms are remarkable.

**RED CROSS NURSE TOTAL.**—The American Red Cross has 30,000 nurses enrolled, of whom 16,000 are serving at the front, according to a report made public on November 3. About 9,000 nurses will be needed in the next few months, and if the war continues for another year about 50,000 more will be needed. The Red Cross is planning a system of enrolling in every city and state. The organization has spent approximately \$850,000 in equipping nurses for the front, while \$1,500,000 has been expended in equipping base hospitals.

**APPOINTMENTS TO MEDICAL RESERVE CORPS.**—The following New England appointments in the United States Medical Reserve Corps were announced:

**Major:** Dr. G. S. C. Badger, Boston, Mass.; Dr. Frederick H. Verhoeff, Brookline; Dr. Frank T. Fulton, Providence, R. I.

**Captain:** Dr. F. B. Clark, Newtonville; Dr. A. P. George, Haverhill; Dr. C. J. Huyck, West Brookfield; Dr. C. E. Street, Springfield; Dr. D. J. Ellison, Lowell; Dr. Joseph N. Boyer, Springfield; Dr. Bial F. Bradbury, Togus, Me.; Dr. Timothy F. Brassil, Cambridge; Dr. Arthur L. Brown, Winchester; Dr. William S. Buckley, Brighton; Dr. Ed-

ward A. Cunningham, Belmont; Dr. Frank E. Draper, Boston; Dr. Jay P. Graham, Springfield; Dr. Willis LeBaron Hale, North Attleboro; Dr. Walter A. Hosley, Springfield; Dr. Arthur E. Joslyn, Lynn; Dr. Ellis S. Leacheur, West Bridgewater; Dr. Donald F. McDonald, Taunton; Dr. David A. McNally, Biddeford, Me.; Dr. Roy H. Peck, Springfield; Dr. Henry B. Potter, Wakefield, R. I.; Dr. Robert A. Rice, Fitchburg; Dr. Bertram H. Caswell, Somerville; Dr. Daniel B. O'Brien, New Bedford; Dr. Charles A. Tetrault, Southbridge; Dr. L. H. Beals, Northampton; Dr. C. M. Deems, Springfield; Dr. G. M. Sheehan, Quincy; Dr. E. G. Sullivan, Springfield; Dr. S. F. Curran, Dorchester; Dr. F. E. Dow, Northampton; Dr. H. H. Germain, Boston; Dr. F. D. McAlister, Lawrence; Dr. S. S. Orr, Weston; Dr. C. Potte, Boston; Dr. D. Williams, Boston.

**First Lieutenant:** Dr. E. McC. Marr, Westfield; Dr. A. W. Slate, Indian Orchard; Dr. John J. Condrick, Brockton; Dr. George H. Hicks, Fall River; Dr. William H. Hunt, Bridgewater; Dr. Herbert L. Mains, Danvers; Dr. Alfred W. Myrick, Randolph; Dr. Francis A. O'Reilly, Lawrence; Dr. Hervey B. Pitcher, Fitchburg; Dr. Frank B. Ruskinigis, Worcester; Dr. Atherton M. Ross, Farmington; Me.; Dr. Charles Shanks, New Bedford; Dr. Warren R. Sisson, Boston; Dr. Max Baff, Worcester; Dr. Ralph N. Brown, Malden; Dr. George A. Connor, Cambridge; Dr. George J. Connor, Haverhill; Dr. Harlan F. Curtis, East Longmeadow; Dr. Arthur A. Cushing, Brookline; Dr. Arthur E. Darling, Lynn; Dr. Fred F. Dexter, Longmeadow; Dr. Ralph O. Dodge, Hyde Park; Dr. Joseph F. Fallon, Brookline; Dr. Philip J. Finnegan, Salem; Dr. Edward J. Fitzgibbon, Dorchester; Dr. Ralph E. Foss, Peabody; Dr. Henry C. Gerrard, Springfield; Dr. Antonio Crasso, Springfield; Dr. Paul J. D. Haley, Medford; Dr. Marcus P. Hambleton, Augusta, Me.; Dr. Dennis W. Hefferman, Holliston; Dr. Ernest L. Hill, Millis; Dr. Fred D. Jones, Springfield; Dr. Howard M. Kemp, Greenfield; Dr. John F. Krasnye, Lowell; Dr. Joseph A. Levek, Lawrence; Dr. Claude A. Loftis, St. Albans, Vt.; Dr. Harry L. McDonald, Attleboro; Dr. Carl E. Meyer, Chicopee; Dr. Edward J. Monahan, Boston; Dr. Frederick P. Moore, East Norfolk; Dr. Frank A. Murphy, Taunton; Dr. John M. Murphy, Brockton; Dr. Joseph B. O'Neill,

Pawtucket; Dr. Vasilios K. Papavast, Providence, R. I.; Dr. Lewis W. Pease, Weymouth; Dr. Leonard H. Pote, Somerville; Dr. Raymond R. Root, Georgetown; Dr. Carleton A. Rowe, Milton; Dr. John M. Salles, New Bedford; Dr. Joseph C. Sullivan, Webster; Dr. Jan E. Tellier, Attleboro; Dr. Elton M. Verney, Peabody; Dr. Orion V. Wells,\* Westfield; Dr. Luther O. Whitman, Amherst; Dr. F. R. Broderick, Worcester; Dr. W. E. Connelly, Dorchester; Dr. J. E. Grady, Leominster; Dr. W. W. Hennessy, Salem; Dr. C. H. Lawrence, Boston; Dr. E. Martin, Boston; Dr. C. A. Ordway, Everett; Dr. L. Phaneuf, Boston; Dr. W. H. Sherman, Graniteville; Dr. J. L. Sullivan, Roxbury; Dr. G. A. Wilkins, Revere; Dr. J. Aaroff, New London, Ct.; Dr. G. H. Binney, Nahant; Dr. T. P. Capeles, Haverhill; Dr. J. P. Carroll, Woburn; Dr. N. M. Crofts, North Adams; Dr. A. R. Cunningham, Boston; Dr. T. A. Devan, Boston; Dr. G. H. Lowe, Jr., Arlington; Dr. E. MacIntyre, Brighton; Dr. A. W. Spaulding, Newton Highlands; Dr. J. J. Condrick, Brockton; Dr. R. Morgan, Westfield; Dr. G. E. Reynolds, Pittsfield; Dr. J. A. Ruel, Haverhill.

#### BOSTON AND MASSACHUSETTS.

**WEEK'S DEATH RATE IN BOSTON.**—During the week ending November 2, 1918, the number of deaths reported was 319 against 238 last year, with a rate of 21.20 against 16.07 last year. There were 38 deaths under one year of age against 38 last year.

The number of cases of principal reportable diseases were: Diphtheria, 19; scarlet fever, 13; measles, 4; whooping cough, 23; typhoid fever, 1; tuberculosis, 49.

Included in the above were the following cases of non-residents: Diphtheria, 4; typhoid fever, 1; tuberculosis, 6.

Total deaths from these diseases were: Diphtheria, 2; whooping cough, 1; typhoid fever, 2; tuberculosis, 11.

Included in the above were the following non-residents: Typhoid fever, 1.

Influenza cases, 200; deaths, 99.

**COLLEGE OF PHARMACY OPENS NEW BUILDING.**—The new building of the Massachusetts College of Pharmacy on Longwood Avenue, was opened last September, but the formal dedication will not take place until later, after

the structure is completed. About 150 students were registered, including 50 women. The building is the gift of George Robert White of Boston.

**MEETINGS OF THE RESEARCH CLUB OF THE HARVARD MEDICAL SCHOOL.**—The recently published memorandum of papers presented by the Research Club of the Harvard Medical School since November, 1917, when a group of research men connected with the Medical School arranged to assemble regularly for the presentation and discussion of papers on scientific subjects, indicates the number of investigators who took advantage of this opportunity for discussion and critical review of their investigations. Announcements of the meetings were sent to members of the various laboratories of pure science in Harvard University and neighboring institutions. The meetings were well attended and papers on a wide variety of subjects were read and discussed. The success of the Club during the past season makes it seem likely that these meetings will become an established custom at the University.

#### PROGRESS OF THE SPANISH INFLUENZA EPIDEMIC.

The Spanish influenza epidemic is on the wane in New England and surroundings. Eleven deaths from influenza and four from pneumonia were reported by the Boston Health Department on November 1, the lowest since September 14. During the week there were reported 130 deaths caused by the epidemic in Boston. Since September 8, there were 4,320 deaths in Boston due to the epidemic. Dr. Wm. C. Woodward, the Health Commissioner, is of the opinion that cases of influenza will continue to show themselves until spring, and reiterates that the public should not fail to exert the utmost precautions to avoid spreading the disease. While there is a periodic slight increase in the number of cases reported, the average decline in mortalities is favorable to a minimum low-ebb which the Board of Health hopes for in the near future. The reports from various parts of the State are as follows:

Fall River, 22; New Bedford, 58 cases and 7 deaths; Plymouth, 10 cases; Taunton, 13; Brockton, 13 cases and 1 death; Cambridge, 13 cases; Franklin, 21; Everett, 11; Haverhill, 25; Lynn, 16; Salem, 14; Lowell, 15; Somerville, 10; Woburn, 12; Worcester, 25; Fitchburg, 24 cases and 5 deaths; Chicopee, 11 cases; Deerfield, 13; Holyoke, 89 (two days); Northampton, 29 cases and 1 death; Springfield, 128 cases and 10 deaths; West-

\* Dr. Wells died without receiving his commission.

Springfield, 128 cases and 10 deaths; Westfield, 12 cases; North Adams, 87; Pittsfield, 5.

In New York City there is a steady decrease in the epidemic. On November 2 there were 2,951 cases as against 2,398 of a few days previous; but November 4 shows only 1,567 new cases. The authorities are of the opinion that the epidemic is practically over in New York.

In Paris, during the week ending October 30, there were 1,263 deaths from influenza, compared with 880 deaths of the previous week.

While influenza cases show a decline in the U. S. Army, there was an outbreak of influenza at Camp Las Casas, Porto Rico. Reports received by the Surgeon General on October 30 showed a total of 3,015 new cases from the total reports, including 562 cases from Camp Las Casas.

A unit of eleven nurses left Boston for Harrisburg, Pa., to assist in fighting the epidemic there. The party consisted of seven nurses and four aids, and went under the supervision of Mrs. Anna M. Staebler, secretary of the Massachusetts Health Industry Commission.

There has been a general decrease in the epidemic throughout Massachusetts, with a few exceptions. Springfield seems to be one of these exceptions. Dr. Brooks has been authorized to establish a hospital there to aid the authorities in combating the disease. The State Guard unit will erect the open-air hospital on the Springfield Hospital grounds. The influenza reports for the last few days show 391 new cases and 15 deaths. The Board of Health has decided to put a quarantine on all influenza patients.

In the Army cantonments both influenza and pneumonia showed a sharp increase up to date. October 27 showed a sharp increase in the influenza cases when the record jumped to 2,486 from the low record of 1,602 cases. October 28 showed a further increase to 2,831 cases.

Mansfield has nine new cases, but schools are again open.

Worcester reports a decline in the number of cases. The number of new cases reported during the week was 84 against 160 the week before.

The base hospital at Lawrence has had no new admissions. The number of new cases reported on October 28 was 29 and four deaths.

Forty Boston nurses have gone to Springfield to help combat the disease there. They are under the direction of Lieutenant Colonel W. A. Brooks of the State Guard Medical Corps. On October 29 the Board of Health reported 85 new cases and six deaths from influenza.

Boston burial permits numbered only 21 on October 29.

Forty-five thousand railroad workers in Prussia and Hesse are incapacitated with in-

fluenza, and passenger traffic is much restricted in consequence.

Bacterial investigation shows that the present outbreak of influenza does not differ from other epidemics of the same malady, the high mortality rate being due to secondary infection, according to a statement made by William H. Fisher in the House of Commons. He added that he saw no reason to believe that the spread of the disease was due to malnutrition of the people. A conference of medical authorities and bacteriological experts was held and research ordered of the causes and nature of the disease.

Reports from cities and towns throughout Massachusetts indicate that the disease is on the decrease. Quincy, which was one of the hardest hit places in the State, was said to be virtually free from the epidemic. Cambridge schools have reopened. Eleven new cases have been reported among the 205,000 enlisted men in the fourteen naval training stations and schools of the First Naval District, but no death has occurred for several days.

Both the Army and Navy are now almost free from influenza. The Free Hospital for Women in Brookline, which for several weeks has been devoted exclusively to the treatment of influenza cases, has reopened its out-patient department. The main hospital was opened on October 28 to receive surgical patients. Between September 8 and October 15 110 cases of influenza were treated at the Franklin Square House. All cases were in charge of Dr. Hilbert F. Day.

New York's average death rate for four weeks preceding the outbreak of the epidemic was 10 per thousand. In the first week of the epidemic it rose to 12, and in the fourth week was 50. The comparative rate during the fourth week in Philadelphia was 158 and in Baltimore 148, while in no large city was it below 70. Public Health Commissioner Cope and urged the public to be vaccinated. Twenty-five soda fountains were closed in the greater city because of unsanitary conditions.

San Francisco reports a total of 2,007 influenza cases and 96 deaths on October 25.

Further subsidence of the epidemic throughout the nation, however, was indicated in reports from 44 states. Over the South and East generally improvement is shown, but the disease is still active in most of the large cities. Continued abatement of the epidemic in army camps was reported. There were reported 2,772 new cases in the army, making a decrease of one from the report of the day before. Pneumonia cases decreased from 742 to 699 and deaths were 307 against 377 the day before. The total influenza cases reported now is 296,275 and pneumonia cases, 48,328, and deaths, 16,174.

**Miscellany.****RESOLUTIONS ON THE DEATH OF DR. HOLMES.**

The following resolutions have been adopted by the Senior Staff of the Boston City Hospital:—

Edgar Miller Holmes was born in Middletown, Connecticut, the son of Giles D. and Emma R. (Miller) Holmes, on May 25, 1868. He met his death by drowning in front of his summer home, at Point Allerton, Boston Harbor, on September 19, 1918.

Dr. Holmes began his professional life as a dentist. After five years he decided that this work was not what he most desired, and entered the Harvard Medical School, from which he graduated in 1895. He was ophthalmological and aural house officer at the Boston City Hospital from January, 1894, to January, 1895; assistant to the aural surgeon, June, 1896; aural surgeon, May, 1899; visiting surgeon for diseases of the ear and throat, April, 1912; member of Administration Board, April, 1917. He was also aural surgeon to St. Elizabeth's Hospital; consulting aurist to the Forsyth Dental Infirmary; instructor in the Graduate School of Medicine, Harvard University; instructor in otology, Tufts Medical School, and for eighteen years aural surgeon to the Boston Dispensary. He was a member of the American Otolological, Pharyngological, and Rhinological Society; New England Otolological and Pharyngological Society, American Academy of Ophthalmology and Pharyngology, American Medical Association, Massachusetts Medical Society, and American College of Surgeons. He belonged to the Unitarian Club and the Harvard Club of Boston.

Dr. Holmes was married twice; in 1895 to Pauline E. Prentiss, of Grafton, who was the mother of his three children, Marjorie, Pauline and Edgar, Junior. After her death he married, in 1907, Lottie A. Crowell.

Dr. Holmes was an indefatigable worker and was intensely interested in his specialty. He devised and invented several valuable instruments, and wrote many monographs. He was an intrepid operator, a clear teacher; could sketch easily and used water colors well. He was kindly and encouraging both to his patients and to the younger members of the profession, and was as conscientious in his hospital work as in his own office. One of the many friends who knew him well writes: "His home life was ideal. He had the ability to leave his cares when he left his office. He could play as well as he could work. His Allerton home showed this—with his fruitful war garden, its many varieties of flowers, its walks and its sea wall, all the work of his own hands."

The Visiting Staff takes this opportunity of placing on record its appreciation of the work

of a colleague, who was associated with the Boston City Hospital in one or another capacity for almost twenty-five years; and of expressing individually the sorrow caused by the death of a comrade, cut off so tragically in the midst of a successful career.

September 24, 1918.

**VOLUNTEER MEDICAL SERVICE CORPS.  
COUNCIL OF NATIONAL DEFENSE.  
WASHINGTON.**

The Council of National Defense authorizes the following statement:

How the civilian physicians of the country have been readily responding to the call of the United States Public Health Service for medical aid in the districts most affected by the epidemic of influenza is reflected in two letters, written a week apart to the president of the Central Governing Board of the Volunteer Medical Service Corps of the Council of National Defense. On September 27 Surgeon General Rupert Blue of the United States Public Health Service requested the coöperation of the Volunteer Medical Service Corps in the following letter:

September 27, 1918.

The President,  
Central Governing Board,  
Volunteer Medical Service Corps,  
Council of National Defense,  
Washington, D. C.

Sir:—

In view of the present epidemic of influenza which if it spreads at the same rate as heretofore, will practically cripple the industries of the country, I have the honor to request that steps be taken to mobilize fifty units of the Volunteer Medical Service Corps, each consisting of ten physicians, for emergency service in connection with the prevention of, and relief from, this disease. Such units, upon mobilization, will be directed to report to officers of the Public Health Service placed in charge of this work.

For the present, the salaries and traveling expenses of these physicians will be borne by the American Red Cross. The salary in each case will be \$200 per month in addition to the reimbursement of their traveling expenses and maintenance.

Anything that your Board may do in this present emergency to mobilize and place at the disposal of the Public Health Service and the American Red Cross such medical units will be deeply appreciated and will serve to demonstrate the value of the recently created Volunteer Medical Service Corps.

Respectfully,  
(Signed) RUPERT BLUE,  
Surgeon-General.

The names of the five hundred doctors asked for were furnished within seventy-two hours. Three days after the first call, another request for five hundred doctors was received from the Public Health Service, and on October 1 the names of 1,135 physicians had been furnished, from whom more than the necessary number

were obtained. On every day since, additional names of volunteers have been coming in, and they have been sent to Surgeon General Blue for his reserve list.

The officers of the Public Health Service expressed gratification at the prompt response from the Washington headquarters of the Volunteer Medical Service Corps, and also for the replies which were being received from doctors in many parts of the country, and on October 4 Surgeon General Blue sent the following letter of appreciation:

October 4, 1918.

The President,  
Central Governing Board,  
Volunteer Medical Service Corps,  
Washington, D.C.

Sir:—

I take pleasure in informing you that the officer in charge of the measures for combating the present epidemic of influenza in New England has stated by telegram that the number of doctors who have already reported for duty is sufficient to meet the needs of the situation in those states.

As you know, these doctors were obtained through the co-operation of your office and it is most gratifying to certify in this way to the prompt response given by your office to our requests for medical assistance. This is an instance which serves to demonstrate the value of the organization of the Volunteer Medical Service Corps in a national emergency like the present.

Respectfully,  
(Signed) RUPERT BLUE,  
*Surgeon General.*

Surgeon General Blue also wired on that day to all State Health Officers as follows:

Public Health Service will mobilize with aid Volunteer Medical Service Corps, all outside medical aid required in combating present influenza epidemic. Red Cross, upon specific request from this service, will mobilize nursing personnel and furnish necessary emergency hospital supplies which cannot be obtained otherwise. Inform all city and county health officers your State that all appeals for aid must be made to State health department which will make request for Surgeon-General, Public Health Service, whenever local needs require. Whenever necessary, Public Health Service will establish district officers to cooperate with State officials and distribute medical and nursing personnel.

Officials at the headquarters of the Volunteer Medical Service Corps are gratified that the organization was able to meet the emergency in this way, fulfilling the purpose for which it was created, namely, to place on record and classify information as to civilian physicians, so that a request for aid voiced by a government department could readily be supplied.

#### RECENT DEATHS.

Dr. A. J. MAKAY, who was in charge of the fight against smallpox here eleven years ago, is dead of acute indigestion. He died at Salem on October 30, 1918. He was born in 1873, graduated from Tufts Medical College and the College of Physicians and Surgeons, Baltimore.

CARL BIRN HUDSON, M.D., Lieutenant, Medical Corps, U. S. A., died in France of pneumonia, October 2, 1918, aged 30. Dr. Hudson was a graduate of Harvard College (1912) and of Harvard Medical School (1916) and was resident surgeon of the East Boston Relief Station. He is survived by his widow, who was Miss Laura Wheeler of Newtonville.

FRED SCATES TOWLE, M.D., a Fellow of the Massachusetts Medical Society, Captain in the Medical Corps, U.S.A., lost his life in a fire which destroyed the officers' quarters at Base Hospital No. 3, Colonie, N. J., October 9, 1918, aged 54 years. Dr. Towle was a graduate of the Medical Department of George Washington University, Washington, D. C., in 1896, was a resident of Portsmouth, and President of the New Hampshire Medical Society, 1917-1918.

FRANCIS AUGUSTUS LANE, M.D., a Fellow of the Massachusetts Medical Society, died at his home in East Lynn of pneumonia, October 29, 1918, aged 61 years. He was born in Peabody. After graduating at Harvard Medical School in 1892, he was quarantined officer and port physician at Boston. He is survived by his widow and two children.

DR. GARDNER H. OSCOON, roentgenologist of the Massachusetts Homeopathic Hospital, died at the Evans Memorial of the Massachusetts Homeopathic Hospital from pneumonia following the influenza. He was born in Boston in 1878 and was graduated from the Boston University Medical School in 1900. He had spent his entire time since graduation from the Medical School in the study of x-ray therapy. He was connected with the Massachusetts Homeopathic Hospital for eighteen years, becoming director of the x-ray laboratory in 1906. He was a member of the Medical Advisory Board No. 41-b, and was daily awaiting his commission in the Naval service.

JAMES JACKSON PUTNAM, M.D., died in Boston on November 4, 1918, at the age of 72 years.

#### The Massachusetts Medical Society.

#### NOTICE TO DISTRICT SOCIETIES OF THE MASSACHUSETTS MEDICAL SOCIETY.

The Public Health Committee of the Massachusetts Medical Society, with a view to increasing the benefits to be derived from membership in the Society and helping the busy practitioner to keep in touch with current matters of practical interest to the profession and pertaining to their daily work, has obtained the consent of the following named gentlemen to speak at meetings of District Societies during the year. In so far as requests may be made and other engagements permit arrangements for designated dates: Prof. William T. Sedgwick, Dr. Walter E. Fernald, Dr. C. Morton Smith, Dr. John Baptiste Blake, Dr. Edwin H. Place, Dr. Victor Safford, Dr. William C. Woodward, Dr. Timothy Leahy, Dr. Jose P. Bill, Dr. George H. Wright, and possibly a representative of the Rockefeller Institute of New York.

The object of these talks is the promotion of public health and increase of knowledge of practical details of daily interest in life of physicians in general practice.

In furtherance of the purpose which the Committee had in view, these gentlemen have offered their services without expense to the members of the Society and are willing to give occasional talks of about thirty or forty minutes, leaving ample time for discussion and questions.

Secretaries of District Societies desiring to arrange speakers from this list should communicate with the Secretary of the Committee, Dr. Annie Lee Hamilton, 141 Newbury Street, Boston, Mass.